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February 17, 2005

The Honorable Michael O. Leavitt
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Leavitt,

Congratulations on your confirmation as Secretary of the Department of Health and Human Services and thank you for taking the time today to testify before the House Energy and Commerce Committee regarding the Administration's fiscal year (FY) 2006 health care priorities. I look forward to working with you to enhance Oregon's and the nation's health care delivery system.

My district, Oregon's Second Congressional District, is geographically larger than thirty-three states and larger than every state east of the Mississippi River. Recruiting and retaining health care professionals to serve in this vast region is very challenging. As I serve Oregonians in Congress and as co-chairman of the bipartisan House Rural Health Care Coalition, ensuring that health care services are available and accessible to rural residents is a major priority of mine.

Grant programs supported by the Health Resources Services Administration (HRSA), especially the Community Health Center program and the Rural Health Outreach grant program, have a dramatic impact in connecting medically underserved rural residents in eastern, southern and central Oregon with health care services. In addition the Medicare Rural Hospital Flexibility program, housed within the Centers for Medicare and Medicaid Services, has ensured that small rural hospitals in my district remain operational through conversion to Critical Access Hospital status. As such, I was concerned to see that these programs were recommended for substantial funding decreases or elimination in the FY 2006 HHS Budget. Regarding this concern and other important issues, I would greatly appreciate your response to the questions listed below.

1. In 2001, Secretary Tommy Thompson established a HHS Rural Task Force that was charged with examining how HHS programs can be strengthened to better serve rural communities. He stated that expanding and improving the provision of health care and social services in rural America is a high priority for this Administration. I know this is an area of priority for the Administration but do you plan to continue the agency-wide rural initiative established by Secretary Thompson?

2. The Administration cites increased Medicare payments to rural providers – provisions of the Medicare Modernization Act (MMA) -- as the sole justification for significant reductions in the Rural Health Care Services Outreach Grant Program administered by HRSA (*Fiscal Year 2006 Budget of the U.S. Government Appendix*, page 429,). However, only 4 of the 118 grants funded between 2001 and 2003 focused on the Medicare population. The vast majority of grantees are not Medicare providers, and thus received no benefit from MMA. I would appreciate your feedback on how HHS reached the conclusion that that these grantees benefited from the provisions of MMA?

3. The Department's program-by-program justification for budget reductions suggests that the payment increases in MMA have significantly addressed the financial ills of the rural health care system. However, this is inconsistent with feedback I am getting from my constituents. Over one year after the passage of MMA, many of my constituents still struggle to access basic health care services and health care providers. Although appreciative of MMA, providers in my district have informed me that they are still reimbursed at a rate that is far below their urban and suburban counterparts. Can you provide me with more detailed information on the Department's particular thoughts regarding how the MMA has contributed positively to the financial struggles of rural health care providers, especially those that do not treat Medicare beneficiaries?

4. In discussions with CMS staff, it seems that hospitals cannot claim, for Medicare Graduate Medical Education payment purposes, the time residents spend in non-hospital sites unless the hospitals pay a supervisory physician some amount, even if that physician agrees to train the resident on a volunteer basis. According to a family practice residency program in Klamath Falls, Oregon, this policy will result in teaching hospitals pulling their residents back into the hospital setting for training, thus limiting residents' exposure to the physician office and non-hospital environment.

   If this is the case – and I would appreciate your thoughts on that – why not let the hospital and physician determine the level of supervisory costs, if any, rather than have the Federal government issue a directive that would fundamentally change a system that has worked well for years?

Thank you very much for your consideration of my concerns. I look forward to your reply. If your staff has questions regarding the concerns outlined in this letter, please contact Valerie Henry of my staff at (202) 226-7343.

Best regards,

Greg Walden
Member of Congress